

COPY



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

OEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

December 30, 2010

Susan Broetje, Administrator  
Idaho State School And Hospital  
1660 Eleventh Avenue North  
Nampa, ID 83687

RE: Idaho State School And Hospital, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the complaint survey of Idaho State School And Hospital, which was conducted on December 29, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Susan Broetje, Administrator  
December 30, 2010  
Page 2 of 2

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 12, 2011**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:


[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)


Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by January 12, 2011. If a request for informal dispute resolution is received after January 12, 2011, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

  
JAMES TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/srm  
Enclosures



# IDAHO DEPARTMENT OF HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG –  
Director

Sue Broetje – Administrative Director  
IDAHO STATE SCHOOL AND HOSPITAL

1680 11<sup>TH</sup> Avenue North  
Nampa, Idaho 83687-5000  
PHONE 208-442-2812  
Fax 208-467-0965  
EMAIL [broetjes@dhw.idaho.gov](mailto:broetjes@dhw.idaho.gov)

# Fax

<b>To:</b> Debby Ransom, R.N., R.H.I.T.	<b>From:</b> Susan Broetje
<b>Fax:</b> 364-1888	<b>Pages:</b> 9 including cover
<b>Phone:</b> 334-6626	<b>Date:</b> 1/10/2011
<b>Re:</b> Plan of Correction – survey 12/29/10	<b>CC:</b>

☐ Urgent    ☒ For Review    ☐ Please Comment    ☐ Please Reply    ☐ Please Recycle

#### Statement of Privacy/Confidentiality

The documents sent in this fax transmission are intended for the person or entity to which they are addressed in this cover sheet. The information in these documents may be privileged, confidential or otherwise protected from disclosure. All persons are advised that they may face penalties under federal law for sharing this information with unauthorized individuals. If you received this information in error, please destroy immediately and call this office at (208)-442-2812 ext 700.



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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EMAIL [broetjes@dhw.idaho.gov](mailto:broetjes@dhw.idaho.gov)

January 10, 2011

Debby Ransom, R.N., R.H.I.T.  
Bureau of Facility Standards  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720

RECEIVED

JAN 11 2011

FACILITY STANDARDS

Dear Ms. Ransom,

Attached is a Plan of Correction to address the deficiency from the complaint survey conducted on December 29, 2010.

If you have any questions please contact me at 208 442-2812 ext 700

Sincerely,

Susan Broetje  
Administrative Director  
Idaho State School & Hospital

Enclosures: Statement of Deficiencies, 12/29/10; Plan of Correction; Cover letter  
12/30/10

SB/ew

**Idaho State School & Hospital**  
Plan of Correction – Complaint survey 12/29/10

**TAG #:** W134

**1. Corrective action for examples:**

NA – the event has occurred and is not correctable.

**2. Other individuals with the potential to be affected and corrective action taken:**

When packages are received for clients, a log will be completed by the switchboard that includes the date of the receipt, the name of the sender, and the name of the client. The package will be delivered within one working day of its receipt.

**3. Measures or a systemic change to ensure deficient practice does not recur:**

The client (or a support staff if the client is unable to document) will sign their name and date for receipt of the package. All staff will be informed that they are not to open client mail or packages, unless the client is unable to do so. In that event, the package or mail will be opening with the client assisting at a level appropriate for their ability.

**4. Monitoring to ensure deficient practice does not recur:**

The QMRP or supervisor will be alerted of the receipt of the package. The log will be maintained on the T-drive and the QMRP will review the log during the monthly Q reviews to ensure the client received the package.

**5. Date when correction action will be corrected (usually within 60 days):**

February 1, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/29/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE SCHOOL AND HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH</b> <b>NAMPA, ID 83687</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<b>INITIAL COMMENTS</b>  The following deficiencies were cited during the complaint survey.  The surveyors conducting the survey were: Jim Troutfetter, QMRP, Team Lead Barbara Dern, QMRP  Common abbreviations/symbols used in this report are: QMRP - Qualified Mental Retardation Professional	W 000		
W 134	<b>483.420(a)(9) PROTECTION OF CLIENTS RIGHTS</b>  The facility must ensure the rights of all clients. Therefore, the facility must ensure clients have the opportunity to send and receive unopened mail.  This STANDARD is not met as evidenced by: Based on staff interview and individual interview, it was determined the facility failed to ensure individuals received unopened mail for 1 of 1 individuals (Individual #11) known to receive mail and had the potential to effect 54 individuals. This resulted in an individual being unable to receive private correspondence. The findings include:  1. Individual #11's record documented a 46 year old female diagnosed with mild mental retardation.  On 12/28/10 Individual #11 stated her Christmas mail had been opened and her gift cards were removed. She further stated the unit shopper was in possession of them.	W 134	<i>See attached</i>  <b>RECEIVED</b> <b>JAN 11 2011</b> <b>FACILITY STANDARDS</b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Abroette</i> <i>Administrative Director</i> <i>1/8/10</i>	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/29/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE SCHOOL AND HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH</b> <b>NAMPA, ID 83687</b>		
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W 134	Continued From page 1  When asked during a phone interview on 12/29/10 at 10:21 a.m., the unit shopper stated all letters and packages were opened during the Christmas holidays to catalog the items individuals received. She further stated she had Individual #11's gift cards in her office.  The facility failed to ensure Individual #11's mail was delivered unopened.	W 134			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/29/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE SCHOOL AND HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM204	16.03.11.075.12(b) Personal Mail  Permitted to send and receive his personal mail unopened, unless medically contraindicated as documented by his physician in his medical records and to make and receive telephone calls in privacy; and This Rule is not met as evidenced by: Refer to W134.	MM204	REFER TO W134		

**RECEIVED**  
JAN 11 2011  
**FACILITY STANDARDS**

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

0A8X11

If continuation sheet 1 of 1



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IDAHO DEPARTMENT OF  
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PHONE 208-334-6626  
FAX 208-364-1888

December 30, 2010

Susan Broetje, Administrator  
Idaho State School And Hospital  
1660 Eleventh Avenue North  
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **December 29, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004880**

**Allegation #1:** Individuals are injured during restraint.

**Findings #1:** An unannounced on-site complaint investigation was conducted on 12/28/10 and 12/29/10. During that time, observations were conducted, investigations and records were reviewed, and interviews with individuals and direct care staff were conducted with the following results:

Observations were conducted on 12/28/10 and 12/29/10 for a cumulative 7 hours 37 minutes. During that time, one individual was noted to be placed in a stand restraint. No individuals were noted to sustain injuries during observations.

Nine investigations, dated 10/27/10 - 12/22/10, were reviewed. None of the investigations documented injuries that were sustained during a restraint.

Thirty six (36) Significant Event Forms dated, 10/21/10 - 12/22/10, documented 22 incidents of prone restraints being used. Of the 22 prone restraints, one documented an individual sustaining a fractured to his left knee and a black eye. An attachment to this incident documented the staff

Susan Broetje, Administrator  
December 30, 2010  
Page 2 of 2

appropriately applied the restraint and the individual did not complain about excessive or unnecessary force being used during the restraint.

Forty one (41) direct care staff were interviewed. All staff consistently reported they had recently been trained in physical restraint techniques and received training on individuals' Behavior Support Plans when the plans were written or revised. Additionally, staff reported clinicians or psych technicians would meet with them every two weeks or as needed to provide additional information.


Four (4) individuals were interviewed with one individual (Individual #2) stating his knee cap was fractured during a prone restraint. However, Individual #2 did not state staff was rough or used unnecessary force during the restraint.


Therefore, the allegation was unsubstantiated with no deficient practice identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

  
JAMES TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/srm